ELECTION FORM FOR THE FLEXIBLE BENEFIT PLAN
PREMIUM ONLY PLAN (POP PLAN)

Employer _____ Employee Name _____

Social Security # _____ Date of Birth _____

Mailing Address _____City _____State_____Zip_____

Home Phone (_____) _____ E-mail **(recommend)** _____

AGREEMENT TO SAVE TAXES ON QUALIFIED INSURANCE PREMIUMS/ OR HSA DEDUCTIONS

☐ YES On the appropriate benefit enrollment form, I have enrolled in certain qualified employer-sponsored insurance benefits (i. e. health, dental, vision or other qualified insurance, HSA Contributions, etc.) I understand that my share of the premium for these employee benefits will automatically be paid with pre-tax dollars. I also understand that if my required contributions for these insurance benefits are increased or decreased while this agreement is in effect, my taxable income will automatically be adjusted to reflect that change.

☐ NO I decline this option for this plan year and understand that I will lose all tax savings that I could receive as participant.

My employer and I agree that my taxable income will be reduced during the year by an equal portion of the benefit elections set forth above and that qualified expenses will be paid on a tax-free basis, I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each Plan Year, I will be offered the opportunity to change my benefit election for the upcoming Plan Year. I acknowledge that I have received, read and understand the Summary Plan Description. I have also read and understand the Important Information provided with enrollment materials.

Employee Signature: _____**Date**_____

TO BE COMPLETED BY EMPLOYER

Employee # _____Plan year start (mm/dd/yy) _____/_____/_____ and end _____/_____/_____

Dept. _____ First payroll start date _____/____/_____ Pay Cycle _____

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